MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** ( ) Yes (x) No
Requestor's Name and Address Wol-Med 2436 I-35 East South, Suite, 336 Denton, Texas 76205	MDR Tracking No.: M4-03-7820-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address State Office of Risk Management Box 45	Date of Injury: Employer's Name: Insurance Carrier's No.: WC1406354

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
09/23/02	09/23/02	99213	$48.00	$48.00
11/05/02	11/05/02	99213	$48.00	$48.00

PART III: REQUESTOR'S POSITION SUMMARY

"The carrier denied full payment for our services on 09/17/02, 12/04/02 and 01/24/03 stating PEC-N Not appropriately documented. Our documentation clearly follows TWCC medical fee guidelines pages 1, 2 and 19."

PART IV: RESPONDENT'S POSITION SUMMARY

Carrier did not respond to this dispute. Denials listed on the EOBs state, "F1-Reduction According to Fee Guidelines. Charge exceeds the scheduled maximum allowance per the Medical Fee Guideline. N-Documentation does not adequately identified/quantified services or supplies billed."

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

The provider submitted documentation that supports the requirements per rule MFG E/M (IV)(C) for CPT code 99213.

Therefore, reimbursement is recommended for this CPT code for the dates of service 09/23/02 and 11/05/02.

PART VI: DETAIL FINDINGS (If needed)

				Total Left Column:			$0.00
				Total Amount Due:			$96.00

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled reimbursement in the amount of **$96.00**. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the requestor within 20-days in receipt of this Order.

Ordered by:

	Michael Bucklin	01/10/05
Authorized Signature	Typed Name	Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____